Newfoundland Labrador

Notifiable Disease Report

CASE ID #: _____
NDR ID #: _____

PART 1: CONTACT INFORMATION

☐ Unable to Contact ☐ Lost to follow up

Patient Name *Last* *First* *Middle*		Alias *Maiden Name*	
MCP#	Sex ☐ *Male* ☐ *Unk* ☐ *Female* ☐ *Other*	Ethnicity ☐ *Caucasian* ☐ *Inuit* ☐ *First Nation* ☐ *Métis* ☐ *Black* ☐ *Oriental* ☐ *Other Asian* ☐ *Unknown* ☐ *Other, specify*	
Birth Date YYYY / MM / DD	Age *Mnths / Yrs*		

Home Address (street or legal description)	City/town	Prov.	Country	Postal Code
Mailing Address (If different from above)	City/town	Prov.	Country	Postal Code

Disease Name	ICD 9 Code (if known)	Confirmation Type (as per case definition) ☐ *Lab-confirmed* ☐ *Clinical* ☐ *Suspect*

Onset Date YYYY / MM / DD	Clinical Diagnosis Date YYYY / MM / DD	Specimen Collection Date YYYY / MM / DD	Lab Test Result Date YYYY / MM / DD	Date Reported YYYY / MM / DD

PART 2: TRANSMISSION / SOURCE DETAILS

☐ Confirmed ☐ Suspect

Transmission Setting

- ☐ *Animal Facility*
  - ☐ *Farm*
  - ☐ *Intensive Livestock Operation*
  - ☐ *Petting Zoo*
- ☐ *Child Care Facility*
- ☐ *Classroom*
- ☐ *Community Organization Function*
- ☐ *Correctional Facility*
- ☐ *Hospital Setting*
- ☐ *Household*
- ☐ *Permitted Food Establishment*
- ☐ *Personal Care Home*
- ☐ *Private Dwelling*
- ☐ *Public Transport*
- ☐ *Restricted Function*
- ☐ *Social Setting*
- ☐ *Sporting Event*
- ☐ *Workplace*
- ☐ *Unknown*
- ☐ *Other*

Source of Infection

- ☐ Animal or Animal Manure Contact
  - ☐ Domestic Pet; specify
  - ☐ Livestock; specify
  - ☐ Other; specify
- ☐ Blood / Blood Product
- ☐ Breast Milk
- ☐ Drinking Water
- ☐ Fecal
- ☐ Food
- ☐ Injection / Intravenous Drug Use
- ☐ Needle stick
- ☐ Other Water (e.g. Beach, Pool, River, etc.)
- ☐ Person-to-Person
- ☐ Respiratory / airborne
- ☐ Sexual Contact
- ☐ Snorting
- ☐ Vertical
- ☐ Unknown
- ☐ Other; specify

PART 3: LABORATORY TEST DETAILS

Test ID: Laboratory Name:

Organism Name	Serotype/Serogroup	Type of Test

Specimen Type

- ☐ *Aspirate Bubo*
- ☐ *Biopsy* _____
- ☐ *Blood*
- ☐ *Brain Tissue*
- ☐ *Bronchial Washings*
- ☐ *CSF*
- ☐ *Cutaneous Vesicular Fluid*
- ☐ *Gastric Washings*
- ☐ *Lesion* _____
- ☐ *Nasopharyngeal Secretion*
- ☐ *Scraping* _____
- ☐ *Secretion* _____
- ☐ *Smear* _____
- ☐ *Sputum*
- ☐ *Stool*
- ☐ *Suspect Food(s)* _____
- ☐ *Swab*
- ☐ *Urine*
- ☐ *Vomitus*
- ☐ *Unknown*
- ☐ *Other* _____

Serology Group	Titre Value(s) Acute	Phage Type
Serology Type	Titre Value(s) Conv	

Syphilis

Staging

☐ *Primary* ☐ *Secondary* ☐ *Early Latent*
☐ *Congenital* ☐ *Unspecified* ☐ *Other, specify*

Syphilis

Blood Screen Dilutions

Date of Blood Report
YYYY / MM / DD

Newfoundland Labrador

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PART 4: RELATED DIAGNOSES & RISK FACTORS

Disease Name	Onset Date YYYY / MM / DD
Comments	
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Comments	
Disease Name	Onset Date YYYY / MM / DD
Comments	

Risk Factors

- ☐ *None Identified*
- ☐ *Alcohol Abuse*
- ☐ *Blood or Blood Product Factors*
- ☐ *Chronic Disease* _____
- ☐ *Diabetes*
- ☐ *Hepatitis B*
- ☐ *Hepatitis C*
- ☐ *Homelessness*
- ☐ *Injection / Intravenous Drug Use*
- ☐ *immunocomprimised*
- ☐ *Postpartum*
- ☐ *Surgical Wound*
- ☐ *Unknown*
- ☐ *Other* _____

PART 5: HOSPITALIZATION

Hospitalized ☐ *No* ☐ *Yes* ☐ *Unknown*

Hospital Name	Date Admitted YYYY / MM / DD	Date Released YYYY / MM / DD	☐ *Died from disease* ☐ *Died from other causes* Date of Death YYYY / MM / DD

Manifestation

- ☐ *Cellulitis*
- ☐ *Epiglottis*
- ☐ *Joint*
- ☐ *Meningitis*
- ☐ *Necrotizing Fasciitis*
- ☐ *Osteomyelitis*
- ☐ *Pericarditis*
- ☐ *Peritonitis*
- ☐ *Pneumonia*
- ☐ *Septicemia / Bacteremia*
- ☐ *Soft Tissue Infection*
- ☐ *Toxic Shock Syndrome*
- ☐ *Unknown*
- ☐ *Other* _____

PART 6: IMMIGRATION AND TRAVEL DETAILS

Likely acquired during <u>TRAVEL</u> outside of Newfoundland and Labrador ☐ *Domestic* ☐ *Foreign*

Location	Departure Date YYYY / MM / DD	Return Date YYYY / MM / DD	Risk Level ☐ *High* ☐ *Medium* ☐ *Low*

Likely acquired during <u>RESIDENCE</u> outside of Canada

Location	Date of Arrival in Canada YYYY / MM / DD	Mode of Travel ☐ *Plane* ☐ *Boat* ☐ *Car* ☐ *Other*

PART 7: RELEVANT IMMUNIZATION DETAILS

Vaccine Type _____ Immunization Date YYYY / MM / DD Vaccine Lot # _____

Immunization Status

☐ *Complete* ☐ *Incomplete* ☐ *None (and eligible)* ☐ *No Documentation (and eligible)* ☐ *Not Eligible* ☐ *Refusal* ☐ *Unknown*

Comments / Reason _____

Future Action _____

PART 8: REPORTING

Comments _____

RHA Public Health Staff	Telephone #	RHA Reporting	Date Reported YYYY / MM / DD